EXHIBIT J

00598

CIGNA

Subscriber Name	Reference Number:	Date of Processing	Member or Patient ID	Member or Patient Name:	Group#	Pag
KEVIN FLYNN	682060830721030	SEPTEMBER 04, 2006	U1359217303	BRENDAN P FLYNN	3211844	01

Provider/Type of Service	Service Date(s)	Charge(s) Submitted	Amount Not Covered	Amount Covered	Patient Deductible	Patient Copay	Covered Balance	Coinsurance	**Total Plan Benefit**	Remark Cod
MELVIN KAPLAN	DATE RCVD: 08/29/06									
PHYSICIAN MEDICAL SERVICES	08/15/2006 08/15/2006	100.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	UC2 039 047
TOTALS		100.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	

Medical Accumulation Information

Benefit Period: 01/01/2006 to: 12/31/2006

	In-Network	Out-of-Network
Individual Deductible Satisfied:	----	300.00
Family Deductible Satisfied:	----	750.00
Individual Out-of-Pocket to Date:	----	1500.00
Family Out-of-Pocket to Date:	----	3249.00
Individual Life-Time Maximum Paid to Date:	----	19700.62

Portion of this Statement Paid by Other Insurance:	0.00
Insurance Portion Paid by your CIGNA benefits:	0.00
Patient Responsibility:	100.00

Explanation of Remarks

UC2 MAXIMUM REIMBURSABLE RATE USED. IF APPLICABLE, ME MBER RESPONSIBILITY IS CHARGED AMOUNT MINUS TOTAL PLAN BENEFIT. PROVIDER MAY BALANCE BILL YOU.
039 MEMBER UNIT LIMIT EXCEEDED.
047 THIS MEMBER HAS EXCEEDED THEIR OUT-OF-POCKET MAXIM UM FOR THIS PLAN YEAR.

G2361E 7-02-2004

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EX. 1